

This form may be completed online, printed and mailed to the address listed below.

Nebraska Department of Health & Human Services
Regulation & Licensure, Credentialing Division
PO Box 94986
Lincoln NE 68509-4986
402/471-4376 or fax 402/471-1066

Affidavit of Practice/Non-Practice

Name: _____ License # _____

Attestation: All applicants requesting reinstatement must complete the following, have their signature notarized, and pay any appropriate fees prior to reinstatement based upon NAC 172 006.02B:

- ☐ I have not practiced nursing *in Nebraska* since my license expired , was placed on inactive or lapsed status, suspended, or revoked.
- ☐ I have practiced nursing *in Nebraska* since my license expired or was placed on inactive or lapsed status, suspended, or revoked.

The actual number of partial or whole days that I practiced is _____

In addition to the applicable reinstatement fee, I have enclosed a fine of \$10 per day for each partial or whole day practiced.

Affidavit:

State of _____ County of _____ I _____ herein
contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Legal Signature of Applicant

Date